option to voluntary nonprofit organizations, not to require them, either directly or indirectly, to undertake criminal fingerprint background checks for employees and volunteers. Chairman MCCOLLUM has assured me, both personally and in his statement, that failure to seek or obtain a criminal fingerprint background check should not be construed as a basis for, or offered as evidence of, liability in civil litigation against a nonprofit voluntary organization where the lawsuit is based on the conduct or actions of an employee or volunteer.

Once again, I would like to congratulate the gentlemen from Florida for their herculean efforts to pass this important legislation, and I thank them for the privilege of making a statement on the bill. I urge my colleagues to vote in favor of the measure.

IN HONOR OF THE PEARL BUCK CENTER'S 45TH ANNIVERSARY

HON. PETER A. DeFAZIO

OF OREGON

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 8, 1998

Mr. DEFAZIO. Mr. Speaker, it is my privilege and honor to congratulate Pearl Buck Center on 45 years of dedicated service to individuals with developmental disabilities.

When Pearl Buck opened in 1953, it was one of the only educational programs in Oregon providing educational services to children with mental retardation and other developmental disabilities. Pearl Buck Center has continued this tradition of leadership in the community, the state, and the nation, providing vocational training, employment, education, and case management services to people with developmental disabilities.

Annually, Pearl Buck Center provides services to about 400 individuals with developmental disabilities and their children. Since it was founded, Pearl Buck Center has helped thousands of adults and children meet the challenges of their disabilities and find opportunities to succeed in school and on the job; to succeed as parents and as self-sufficient individuals; and to contribute to the community and society.

I would like to acknowledge the hard work and spirit of service that characterizes this organization. I hope that all Americans will reflect on the dedication of the staff and volunteers of Pearl Buck Center and on the struggles and successes of the individuals they serve.

I extend my deepest appreciation and thanks to Pearl Buck Center for their efforts, past and present, to help individuals with disabilities more fully realize their abilities, potential, and independence. We are all richer for your 45 years of service.

SPECIAL RECOGNITION OF SENATOR BEN GAETH (DEFIANCE–OH) UPON HIS RETIREMENT FROM PUBLIC SERVICE

HON. MICHAEL G. OXLEY

OF OHIO

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 8, 1998

Mr. OXLEY. Mr. Speaker, I rise to honor a true public servant and long time friend, Senator Ben Gaeth of Defiance, Ohio. Senator Gaeth served with distinction from 1975 to the present in the Ohio Senate, and during that time I had the privilege of working with him on many issues of the day. Ben has also represented my home county of Hancock for 23 years during his tenure in the Senate and has always been a responsive and responsible legislator who has represented the best interest of his constituents during his illustrious career.

Senator Gaeth was first elected to the Senate in 1975 serving the people of the 1st Ohio Senate District. Before this he was Safety Director for the City of Defiance from 1962 until 1965. After this, he went on to serve a long career as the Mayor of Definance until 1974. He has served as President in the Mayor's Association of Ohio as well as the Ohio Municipal League.

He has fought to preserve our nation's heritage and our children's freedom. He was wounded while in the Navy in the Pacific and Atlantic War Theaters. Mr. Speaker, Senator Gaeth is a true American Hero.

His many civic duties and charities include the Defiance Area Chamber of Commerce, Rotary Club, Masonic Lodge, Order of the Purple Heart, Veterans of Foreign War, Amvets, American Legion, Loyal Order of Moose, Eagles, and BPO Elks. As you can readily see, it is a wonder that he has had any time to raise a wonderful family.

He has three children, seven grandchildren and one great-grandchild.

In closing, Mr. Speaker, we extend our best wishes to Ben and his lovely wife, Thelma, on this well earned retirement. Ben and Thelma have truly been inspirations to all of us in public service and have exemplified all that is best about politics and government.

IN HONOR OF THE 50TH ANNIVERSARY OF THE GERMAN SCHOOL COMMITTEE

HON. LOIS CAPPS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 8, 1998

Mrs. CAPPS. Mr. Speaker, I rise to bring to the attention of my colleagues the 50th Anniversary of the German School Committee in San Luis Obispo, California on October 24, 1998.

The year 1998 marks the 50th Anniversary of the German School Committee exchange student program between San Luis Obispo High School in San Luis Obispo, California and Eberhard Ludwigs Gymnasium in Stuttgart, Germany, as the second oldest international student exchange of its kind.

The German School Committee began in 1948 at San Luis Obispo High School as a postwar goodwill project affiliated with the American Friends Service Committee, which sent goods to Eberhard Ludwigs Gymnasium students.

Ethel Cooley, former Dean of Women at San Luis Obispo High School, directed the program from 1948–1991, and Chris Hovis and Deborah Nelson have directed the program from 1992 to the present. A true student exchange program and a strong bond between the two high schools has developed during the past 50 years, enriching the students' and families' lives by building cultural bridges in their respective communities.

Mr. Speaker, I congratulate the German School Committee student exchange program on their 50th Anniversary, and for fostering friendships between students from culturally diverse backgrounds.

CLOSING THE HUGE HOLE IN MEDICARE'S BENEFITS PACKAGE: STARK INTRODUCES MEDICARE PRESCRIPTION DRUG BENEFIT

HON. FORTNEY PETE STARK

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 8, 1998

Mr. STARK. Mr. Speaker, I rise today to introduce the Medicare Prescription Drug Coverage Act of 1998 to remedy a huge hole in the program's benefits package—outpatient prescription drug coverage. Twice in the past 10 years, Congress has almost provided this benefit, and twice we have failed. We established a drug benefit in the Medicare Catastrophic legislation of 1988, but it was repealed the next year before the benefit could start. A drug benefit was a key component of H.R. 3600, the Health Security Act of 1994, reported by the Ways and Means Committee, but failed to pass that year.

It is time to debate this issue again and try some new approaches.

While Congress has done nothing, drug costs have been soaring out of the reach of millions of seniors enrolled in traditional Medicare.

In 1995, 46% of seniors enrolled in fee-for-service Medicare were without drug coverage. Almost one-quarter of beneficiaries enrolled in Medicare HMOs (about 4% of all beneficiaries) do not have a drug benefit.

And in the face of projections that prescription drug prices are about to spike again, following a brief slowdown during the 1993–94 health care reform debate, the number of seniors with no drug benefits could accelerate.

By 2007, the Health Care Financing Administration projects drug costs will account for over 8% of total health care costs, up from 6% in 1996. Viewed another way, that could mean double-digit price increases. For many beneficiaries with modest incomes, no retiree health coverage, and too many assets to qualify for Medicaid, these economic trends mean they will be forced to rely on traditional Medicare—with no drug coverage.

In effect, we are rapidly creating a large underinsured class of Medicare beneficiaries.

So as we approach the millennium, I will pose the question again: Why doesn't Medicare have a drug benefit? Why do nearly all Americans who have private insurance, which includes every member of Congress, enjoy drug coverage, while millions of seniors do not?

Most Americans have heard stories about seniors who must make repeated, difficult choices to buy either prescription drugs or other necessities—like food. The health toll this produces is not easy to quantify. Researchers report that seniors without drug coverage frequently decide to go without medications for conditions such as headaches and muscle aches. What is less well known is that

many of these same seniors also decide to skimp on drugs to treat potentially serious diagnosed conditions, including leg swelling and diabetes.

This year, I have heard from many, many distraught seniors who have written to tell me they are going broke trying to pay for drugs their doctor told them they must take. I believe that some will wind up in worse health when they decide to forgo or cut back on the very drugs designed to keep them clinically stable.

The absence of a prescription drug benefit in Medicare that forces elderly people to skip and skimp on drugs is inexcusable. It is time for Congress to debate and enact legislation that will provide all seniors who want it access to affordable Medicare-sponsored drug coverage.

There really aren't any good alternatives. Trends in employer-sponsored retiree health coverage—which has traditionally featured a drug benefit—show it is eroding. A somber General Accounting Office report released last summer warns that ''while an estimated 60 to 70% of large employers offered retiree health coverage during the 1980's, fewer than 40% do so today, and that number is continuing to decline despite the recent period of strong economic growth.'' That's a polite way of pointing out that the number of U.S. companies offering their retirees health coverage in the last decade has been dropping like a stone.

For those seniors who don't—and won't—have retiree health coverage, purchasing a supplemental policy with good drug coverage may soon be unaffordable. Supplemental Medigap policies now costs on average more than $1,200 per year, according to the American Association of Retired Persons. But Medigap policies with drug coverage can cost far more. The range in costs for Medigap policies with drug coverage is also large: In Los Angeles, Bankers' Life Insurance and Casualty sells a drug-Medigap policy for $6,381 at age 65. At age 75, the same policy costs $9,174! The difficulty that seniors have in affording comprehensive supplemental insurance is illustrated by the fact that in 1994–95, a mere 15% of seniors purchasing a Medigap policy had drug coverage.

The hard fact is that a Medigap policy with drug coverage is not now—and will never be—within the financial reach of millions of Medicare beneficiaries, particularly the very old, who are spending down their assets.

That brings us to Medicare managed care. Remember, one quarter of those who are enrolled today don't have any drug coverage. Those who do are facing ever-higher deductibles and copayments, and ever-lower annual reimbursement caps. In Massachusetts, where state law has long required all HMOs to offer drug coverage, Medicare managed care plans are now asserting that last year's Balanced Budget Act says they don't have to comply!

Only recently have seniors begun to understand that the comprehensive drug benefit they were promised in glossy HMO marketing materials is the equivalent of a ''low introductory rate'' pitch made by credit card companies. It's great while it lasts. But after that, you could be in trouble.

The Medicare Prescription Drug Coverage Act is carefully designed to help those who most need an outpatient drug benefit—who don't get it from a former employer, from Medicaid or any other federal health program, and who pay an extra premium under Part B for Medicare drug coverage.

I am introducing this bill, roughly modeled on the 1994 legislation, so that consumers, pharmaceutical providers and others can study the issue over the winter, comment and suggest changes for a revised bill to be introduced at the beginning of the 106th Congress. I am leaving the numbers for the deductible, the caps, and the premiums blank, so that groups can comment on what they think the appropriate combination of figures should be.

In a separate statement, I am reprinting some of the literature that is available on the cost of different prescription drug benefit plans at different deductible levels. Clearly, there is a tradeoff between the size of the benefit and its affordability: Striking the right balance is the key to the passage of successful legislation.

There is a critical distinction between previous proposals for Medicare drug coverage and the legislation I am introducing today: If you already have an adequate prescription drug benefit, you will not have to ''pay again'' in higher Part B premiums. If you have coverage, there will be no change and no new cost to you. If you do not have a prescription drug benefit, you will face a higher Part B premium, but if you are low income, you will get assistance in paying for it. While it is tempting to say that the decision to enroll in the prescription drug benefit could be voluntary, the adverse risk selection (i.e., only sick people needing lots of costly prescriptions would be likely to sign up) would make the cost of premiums to those enrollees prohibitive.

Adding an outpatient drug benefit to Medicare is not cheap. But IF prices are set at the ''wholesale'' level that physicians, medical suppliers and other purchasers pay, and IF all budgetary savings are not immediately earmarked for tax cuts, then Medicare drug coverage is affordable.

In the next Congress, we will have another opportunity to reshape Medicare to make it a better program. As we work to stabilize the program's financing, we must also improve it for those it was created to serve—our nation's seniors.

Without drug coverage, more and more seniors will fall through the widening cracks of a health care system that is getting leaner and meaner.

Without drug coverage, we'll see more seniors who can't afford to take their medications treated in the emergency room, where health care costs are highest.

Adding a prescription drug benefit to Medicare along with a requirement that costs be held to reasonable levels and a reasonable rate of growth is a clear way out of this dilemma. It is legislation that is 33 years overdue. I hope my colleagues will join me in vigorously advocating for passage of the Medicare Prescription Drug Coverage Act in the 106th Congress.

THE NATIONAL ALLIANCE: HATRED AND BIGOTRY IN ITS MOST FRIGHTENING FORM

HON. TOM LANTOS

OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES

Thursday, October 8, 1998

Mr. LANTOS. Mr. Speaker, I would like to ask my colleagues to join me in studying the recently released report of the Anti-Defamation League (ADL) entitled Explosion of Hate: The Growing Danger of the National Alliance. This comprehensive and well-written document addresses the activities and proclivities of one of the most dangerous hate groups in America, the neo-Nazi National Alliance.

The stated goal of the National Alliance is to secure ''a racially clean area of the earth . . . no non-whites in our living space . . . a thorough rooting out of Semitic and other non-Aryan values and customs everywhere.'' To achieve this warped end, this organization of intolerance pledges ''to do whatever is necessary to achieve this White living space and to keep it White. We will not be deterred by the difficulty or temporary unpleasantness involved.'' Indeed, the ADL report details the depths of ''temporary unpleasantness'' to which the National Alliance has sunk in its pursuit of its depraved agenda, tracing numerous cold-blooded murders and other terrorist activities to National Alliance members. Declared National Alliance leader William L. Pierce: ''We should not flinch from this. We should not focus on the fact that it will be horrible and bloody, but on the fact that it is necessary, and because it is necessary it is good.'' The dramatic growth of this frightening organization over the past several years should alarm us all.

Mr. Speaker, I would like to enter into the RECORD selected portions of ''Explosion of Hate: The Growing Danger of the National Alliance.'' I hope that my colleagues will read the entire report on the ADL's web site at www.adl.org.

EXPLOSION OF HATE: THE GROWING DANGER OF THE NATIONAL ALLIANCE

INTRODUCTION: THRIVING ON HATE

The Most Dangerous Organized Hate Group

A new ADL investigation reveals that the neo-Nazi National Alliance (NA) is the single most dangerous organized hate group in the United States today. The NA sprang to national attention several years ago, when it was discovered that a fictitious incident in The Turner Diaries, a violent and racist novel written by the NA's leader, might have been used as a model for the Oklahoma City bombing. Convicted bomber Timothy McVeigh was a devoted reader of The Diaries, which features a bombing scenario that is eerily reminiscent of the April 19, 1995 blast. The book was also the blueprint for The Order, a revolutionary terrorist group that robbed and murdered its way to fame in the early 1980s. The ringleader of The Order was an organizer for the NA.

Now, the National Alliance has leaped to prominence again. In the last several years, dozens of violent crimes, including murders, bombings and robberies, have been traced to NA members or appear to have been inspired by the groups's propaganda. At the same time, the National Alliance's membership base has experienced dramatic growth, with its numbers more than doubling since 1992. The group, headquartered near Hillsboro, West Virginia, is led by former University of Oregon physics professor and veteran anti-Semite William L. Pierce.

Active Cells From Coast to Coast

With 16 active cells from coast to coast, an estimated membership of 1,000 and several thousand additional Americans listening to its radio broadcasts and browsing its Internet site, the National Alliance is the largest and most active neo-Nazi organization in the nation. The group has also developed significant political connections abroad. In the past three years there has been evidence of